Maternal Health Services at the Community Level in Afghanistan: Who Should Provide These Services?

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MINISTRY OF HEALTH
POLICY STATEMENT

SAFE MOTHERHOOD INITIATIVE IN AFGHANISTAN

MATERNAL HEALTH SERVICES AT THE COMMUNITY LEVEL

AND

WHO SHOULD PROVIDE THESE SERVICES

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Ministry of Health
TRANSITIONAL ISLAMIC GOVERNMENT OF AFGHANISTAN

Safe Motherhood Initiative in Afghanistan

Maternal Health Services at the Community Level and Who Should Provide These Services

The reduction of Afghanistan's high maternal mortality ratio is a principle objective of the Ministry of Health's Reproductive Health Strategy. A central initiative that will substantially contribute to this strategy is the country-wide expansion of maternal health services, specifically the expansion of essential obstetric care services, at all levels of the health system – from facilities to communities. To do this will require the training, deployment and support of skilled birth attendants to both rural and urban areas. Midwives and doctors must be taught the interventions that are currently thought to be the most important and will have the greatest impact in improving health maternal and newborn health and preventing mortality.

Needs of the Community

The maternal and newborn health services that are necessary, feasible and thought to be effective at the community level include:

- Community awareness and support for the seeking of health services, following the principles of community-based health care;
- Antenatal care (basic history, examination and care provision, including birth planning, tetanus immunization, and distribution of iron and folate);
- Health education (nutrition, birth planning, danger signs) to women, families and communities;
- Postnatal care for mothers and newborns (basic history, examination and care provision, including support of breast feeding and distribution of iron and folate);
- Identification of complications and abnormalities that need emergent, urgent and scheduled referral;
- Provision of family planning methods (LAM, condoms, COCs and DMPA).

Efforts should be made to ensure that trained community-level health providers are able to provide these services, at a minimum.

As well, the community must be connected to the formal health system and must be able to access the health facilities (BHC, CHC and/or hospital) that can provide them with an expanded set of appropriate maternal and newborn health services.

International Evidence Regarding Who Can Provide Selected Services

In an effort to reduce high maternal and newborn mortality, the global health community has directed its efforts toward ensuring that appropriate maternal and newborn health services are available to women and newborns. These ideas are unified in a concept known as *Essential Obstetric Care*. The current feeling is that, while a community health worker can provide the basic care outlined above, the management of birth, and its potential complications, is best managed by a **skilled birth attendant**.

The WHO, in collaboration with UNFPA, UNICEF and the World Bank make the following statement regarding the skilled attendant[1].

[1] http://www.who.int/reproductive-health/global_monitoring/skilled_attendance.html

"The term 'skilled attendant' refers exclusively to people with midwifery skills (for example midwives, doctors and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications. At minimum the person must be competent to manage normal childbirth and be able to provide emergency (first line) obstetric care. Not all skilled attendants can provide comprehensive emergency obstetric care although they should have the skills to diagnose when such interventions are needed and the capacity to refer women to a higher level of care."

"Traditional birth attendants, either trained or not, are excluded from the category of skilled attendant at delivery."

By this definition, a skilled provider in the Afghanistan context would include a:

- Community midwife,
- Midwife, or
- Doctor.

Again, by this definition and by international consensus and experience, the traditional birth attendant (trained or untrained) would not meet the criteria for skilled attendant. The main reason is that TBAs do not possess the necessary skills to manage the obstetrical complications that can result in maternal mortality. In the past 10 years important information has been presented which support this decision.

- The metanalysis of 63 TBA training[2] programs showed that while training has a positive effect on TBA's knowledge, attitude, behavior and advice, this training actually had a negative effect on maternal mortality and a marginal effect on perinatal/neonatal mortality.
- A study of TBA training in Ghana[3], showed that while TBA training resulted in a significant decrease in intrapartum fever and retained placenta, this was counterbalanced by an increase in the rate of women with prolonged labor >18 hours. The authors conclude that "the evidence for beneficial impact of TBA training on the health of mothers and newborns is not compelling."
- A study comparing the practices of trained and untrained TBAs in Bangladesh[4] showed that, although trained TBAs were more likely to practice clean delivery, the infection rates among patients of trained and untrained TBAs was no different. This is likely due to the fact that the factor most directly affecting postpartum infection is length of labor and duration of ruptured membranes.

As well, international opinion has shifted *from supporting TBAs as providers* of delivery services, to one in which health infrastructure must be developed to attempt *to provide skilled attendance for all pregnant women* and ensure access to emergency obstetrical care services.

- The substantial reduction in maternal mortality in countries such as Malaysia, Sri Lanka, China and Honduras have all included, among other things, a policy of enhancing skilled attendance and reducing the utilization of traditional birth attendants at birth.
- The 1997 Global Conference on Safe Motherhood in Colombo, Sri Lanka stated that "maternal mortality is an issue of health infrastructure" and efforts should be directed to "ensure a medically skilled attendant at every birth".
- UNICEF and WHO have adopted a policy, especially in situations where resources are limited, of enhancing the availability of emergency obstetric care, and not training TBAs.

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[2] Sibley and Sipe, 2002; TBA Training and Effectiveness, A Meta-analysis.
[3] Smith, JA, et al, The impact of traditional birth attendant training on delivery complications in Ghana, Health Policy and Planning; 15(3): 326-331.
[4] Goodburn, EA, et al, Training traditional birth attendants in clean delivery does not prevent postpartum infection, Health Policy and Planning; 15(4): 394 – 399.

- In most programs around the world, USAID has discontinued the support of TBA training programs.

The Role of the TBA and CHW

The exact percentage of births in Afghanistan that are attended by TBAs is unknown. The most reliable data comes from the 2003 MICS survey by UNICEF, which suggests the following:

Type Of Attendant	% Of Births Attended
Doctor, midwife, nurse	8.0%
Trained or untrained TBA	8.8%
Relatives, friends, others	83.1%

These findings suggest that TBAs do not currently provide broad support to the birthing process in Afghanistan. The activities of TBAs will continue for many years, and in many communities throughout Afghanistan the TBA will continue to be a support person to pregnant women and should be encouraged in that role. The evidence, however, does not suggest that scarce resources should be devoted to training, supervising or equipping them as birth assistants.

Community-level workers can and do still serve a vital role in the lives and experiences of pregnant women. The efforts of community level workers can be focused along the lines of the CHW job description. Their efforts can be directed to focus on

- acting as community educators to lend support for accurate maternal and neonatal health messages (e.g., nutrition, TT vaccination, etc.);
- identifying pregnant women in the community and linking them with appropriate maternal health services;
- partnering with skilled providers (especially midwives and community midwives);
- promoting birth preparedness and complication readiness;
- providing directed, limited antenatal care, including the distribution of iron and folate, and tetanus immunization, etc., and
- identifying and referring sick newborns;
- understanding and accessing referral systems more readily, and ensuring the continuum of care during the referral process;
- providing selected family planning methods.

The Position of the Ministry of Health of Afghanistan

To remain consistent with international thinking and the preponderance of evidence, the Ministry of Health proposes a strategy of

- promoting skilled attendance at birth and
- enhancing the skills and roles of community health workers (CHWs) to provide appropriate health services according to her/his job description and support the health-seeking behaviors of a pregnant woman and her ability to access skilled delivery services.

Midwives and community midwives must be recruited, trained[5], deployed and supervised as skilled attendants to serve the needs of the rural areas. Community midwife training programs should be implemented in rural areas, especially those provinces that currently have a large percentage of births attended by TBAs. These newly deployed community midwives should make additional efforts to work with women and communities that have relied on TBAs and build their own place and role as skilled providers.

[5] Training curricula have been prepared and the new and expanded training program for midwives and community midwives is underway.

The MOH proposes that

- CHWs, especially female CHWs, be trained in a strategy of birth preparedness and complication readiness including antenatal care, identification of complications, and realistic strategies for referral, including postpartum referral;
- training of TBAs as birth attendants be discontinued;
- TBAs be invited to participate in CHW training, thus becoming female CHWs;
- illiterate TBAs/CHW candidates be able to participate in specially-designed CHW training programs for low to no literacy;
- highly literate women currently serving as TBAs will be encouraged to enroll in community midwife training programs;
- linkages between CHWs and health facilities be strengthened through mechanisms such as resupply, clinical supervision, reporting, participation in the development and implementation of health facility's workplans, etc.;
- midwives and community midwives be trained and deployed to meet the needs for skilled care at birth, and to provide the necessary linkage with the community health workers, and;
- health facilities be supported to provide care for pregnant women, especially basic or comprehensive essential and emergency obstetric care, as appropriate.

Efforts of demand generation and CHW training must be closely coordinated with initiatives to improve the quality and accessibility of health services. This strategy to shift toward professional care at birth must be supported by messages to families and communities about the value of skilled care at birth and the avoidance of dangerous practices. Given that the percentage of births attended by familiy members is overall rather high, messages that recommend positive practices and discourage harmful practices must be directed to the community as a whole, not only to CHWs or TBAs. Male as well as female CHWs must work with broad sectors of the community to promote birth preparedness and complication readiness and support women in the reasonable development of birth plans. Pictoral flip charts should be developed which can be used by CHWs to guide women and families in preparation of birth plans and the decisions regarding pregnancy and childbirth.

Conclusion

It is recognized that this is a long-term vision for the improvement of maternal care in Afghanistan. Short-term strategies, however, must support the long-term vision. It would be unwise to devise a short-term strategy that temporarily promotes the use of TBAs knowing that this strategy will be reversed in the coming years. There is a real potential that promoting opposing strategies (one that supports the use of TBAs followed by one that discourages the use of TBAs) could result in confusion at the community level and loss of trust in the health system.

Additional technical information regarding this policy and strategy is available from:

- Dr. Ferozuddin Feroz, Deputy Technical Minister, MOH
- Dr. Hedayatullah Stanakzai, Director of Policy & Planning, MOH
- Dr. Abdullah Fahim, Director of Health Care and Promotion, MOH
- Safe Motherhood technical advisors from UNICEF and USAID/REACH.